Mexican adults and is adding a new member on the average of every two weeks. The Mexican model as established in San Miguel de Allende, a community of 90,000 persons, includes the traditional services of peer counseling, independent living skills training, advocacy, information and referral, and outreach, but in the absence of a rehabilitation hospital, vocational rehabilitation workshops, and other resources, El Centro set about filling other gaps in services. First, a liaison was created with the town's quality care hospital, Unión Medica, which is affiliated with the School of Medicine of the University of California, San Diego. Members of El Centro receive routine, specialized, and emergency care through this facility. Next, El Centro attracted the volunteer services of a retired occupational therapist from the United States and a physical therapist with extensive experience in medical facilities in Mexico City. A Mexican male nurse was hired on a full-time basis to provide service in the home, particularly to members who are paralyzed. A group exercise program was started. Hydrotherapy is available at a nearby hot springs resort. Group psychological services were begun with a volunteer Mexican psychologist.

Transportation—a new pickup truck—was obtained when the group received proceeds from the national lottery. The group also successfully advocated for lottery funds to construct workshops. With start-up help from the community, El Centro equipped a jewelry-making workshop, began a job placement service, formed a wheelchair basketball team, secured donated rental housing, and purchased wheelchairs and wheelchair parts. A program of social activities was established early in the formation of the program.

El Centro plans to start a wheelchair manufacturing and sales business. Other small businesses being planned are wearable art, ceramics, garment making, and bicycle repair.

El Centro is entirely composed of adult Mexicans who are challenged by severe disabilities. A support group, "Los Amigos," open to all interested persons, helps with fundraising and public relations.

El Centro is encouraging other groups of adult disabled Mexicans to replicate the San Miguel model.

Rehabilitation in Great Britain

A. K. CLARKE, FRCP
Bath, Avon, Great Britain

GREAT BRITAIN probably is unique in the developed world in that the specialty of rehabilitation medicine is just becoming recognised. In many respects this is an accident of history. When the various groups of spa doctors and others using physical methods of treatment came together between the First and Second World Wars, they designated themselves consultants in physical medicine. With the passage of time, it became clear that most patients they were treating were suffering from rheumatic diseases, and the specialty of rheumatology emerged. This contrasts with most other countries where rheumatology arose from internal medicine. Most rheumatologists, especially outside the main teaching centres, also ran the rehabilitation services. Other features that delayed the emergence of a rehabilitation specialty were the comparative rarity of spinal injury in Britain, strong family practice, amputation services being run by a government service entirely separate from the National Health Service, and the well developed, if underrated, professions of physiotherapy and occupational therapy.

One consequence has been that rheumatologic rehabilitation has become highly developed. A recent government survey has shown that not only do the rheumatic diseases form the largest group of disabling conditions in Britain, but they also represent the largest number of severely disabled people in the country at this time. There are only around 350 full-time rheumatologists in Britain—for a population of 56 million—but they are well spread throughout the country, uniformly trained and experienced, and tend to offer good rehabilitation for their patients.

A number of people are involved in the care of patients. A rheumatologist will establish the diagnosis, make an attempt at predicting outcome, and initiate drug, physical, and, if appropriate, surgical treatment. A physiotherapist will provide assessment of disability and the requirements for treatment, education of the patient, and certain physical modalities. Of these the most important is exercise, which has been shown to be of benefit in a range of conditions.

The occupational therapist's responsibilities include hand assessment, activities of daily living, wheelchair assessment, and home visiting. Help will be given with household and personal chores and with improving the workplace, often with the provision of technical equipment. Joint protection is an important educational topic. Splint-making may be done by a physiotherapist, occupational therapist, or an orthotist. A social worker provides advice on financial matters, assists with re-housing, and can provide a counseling service for family and other personal problems. Apart from making simple splints, orthotists have a special role in rheumatology in the provision of footwear. Painful feet are a major problem in diseases such as rheumatoid arthritis. Rheumatology nurses also have special skills, including education and help with preventing and treating skin ulceration, which is common in the rheumatic diseases.

There is a strong tradition in Britain to provide support for unemployed people, including assessment and placement. This applies to disabled people as well as able-bodied ones. Disablement resettlement officers are the important link and are found in every major town and city. They are responsible for a wide range of services provided by the government to help people with work-related problems because of ill health or disability. Another strong tradition is the wide range of self-help and charitable groups working in Britain. For rheumatic patients, they range from Arthritis Care and the National Ankylosing Spondylitis Society, which are mainly concerned with patient welfare, to the Arthritis and Rheumatism Council, whose main job is to fund research and education into all aspects of these crippling diseases.

Rheumatic patients in Britain are better off than many of their disabled peers, most notably those with neurologic disease. Rheumatologists in Britain understand and practice rehabilitation as part of total patient care. They have built excellent teams to assist them. The need now is to extend that practice to all rheumatic sufferers and more widely to all disabled and handicapped people by establishing a proper specialty of rehabilitation medicine in Britain.

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From the Royal National Hospital for Rheumatic Diseases, Bath, Avon, Great Britain.

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